SERFF Tracking Number:	*AMNA-126820721*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46972*
Company Tracking Number:	*SLAICO - FELA10*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SLAICO - FELA10*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Standard Life and Accident Insurance Company

Product Name: SLAICO - FELA10	SERFF Tr Num: AMNA-126820721	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num: 46972
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num: SLAICO - FELA10	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Tyra Reed	Disposition Date: 10/07/2010
	Date Submitted: 10/04/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/07/2010	Explanation for Other Group Market Type:
	State Status Changed: 10/07/2010
Deemer Date:	Created By: Tyra Reed
Submitted By: Tyra Reed	Corresponding Filing Tracking Number: 42035

Filing Description:

RE: Standard Life and Accident Insurance Company (NAIC: 86355 FEIN: 73-0994234) Filing Of:
FELA10SALI - Application to Standard Life and Accident Insurance Company
FELA10TSALI - Telephone Application to Standard Life and Accident Insurance Company
SERFF Tracking Number: AMNA-126820721
Company Tracking Number: SLAICO – FELA10

Please find attached the above listed forms for your department’s review and approval.

SERFF Tracking Number:	*AMNA-126820721*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46972*
Company Tracking Number:	*SLAICO - FELA10*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SLAICO - FELA10*		
Project Name/Number:	*/*		

FELA10SALI is an application form used in person to person agent solicited scenarios.

FELA10TSALI is the application form used for the telephone application process, where the applicant, agent, and call center representative participate in completing the application via telephone. A copy of the telephone procedures have been provided under the Supporting Documentation tab.

Form FELA10TSALI will replace the previously approved forms FEAWL09 and FEA09, approved 4/3/2009 under ANTX-126096883 (State Tracking Number 42035).

FELA10SALI and FELA10TSALI will be used to apply for the previously approved (9/6/2006) Form 2004-891 (a whole life product).

Additional information/supporting documentation included in this submission is as follows:
- Statement of Variability for each application
- Certificate of Readability
- Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.
- Payment of the required filing fee in the amount of $100.00 has been submitted via EFT.

Company and Contact

Filing Contact Information

Tyra Reed, Policy Analyst	tyra.reed@anico.com
One Moody Plaza	409-763-1112 [Phone] 5222 [Ext]
Product Development--14th Floor	409-766-6933 [FAX]
Galveston, TX 77550	

Filing Company Information

Standard Life and Accident Insurance Company	CoCode: 86355	State of Domicile: Texas
Administrative Office:	Group Code: 408	Company Type: LifeHealth and Annuity
One Moody Plaza	Group Name:	State ID Number:
14th Floor	FEIN Number: 73-0994234	
Galveston, TX 77550		
(409) 763-4661 ext. 5222[Phone]		

SERFF Tracking Number:	*AMNA-126820721*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46972*
Company Tracking Number:	*SLAICO - FELA10*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SLAICO - FELA10*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	$100.00	10/04/2010	40228186

SERFF Tracking Number:	*AMNA-126820721*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46972*
Company Tracking Number:	*SLAICO - FELA10*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SLAICO - FELA10*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/07/2010	10/07/2010

SERFF Tracking Number:	*AMNA-126820721*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46972*
Company Tracking Number:	*SLAICO - FELA10*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SLAICO - FELA10*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/07/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMNA-126820721*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46972*
Company Tracking Number:	*SLAICO - FELA10*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SLAICO - FELA10*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statement of Variability		Yes
Form	Application to Standard Life and Accident Insurance Company		Yes
Form	Telephone Application to Standard Life and Accident Insurance Company		Yes

SERFF Tracking Number:	*AMNA-126820721*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46972*
Company Tracking Number:	*SLAICO - FELA10*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SLAICO - FELA10*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FELASALI10	Application/ Enrollment Form	Application to Standard Life and Accident Insurance Company	Initial			FELASALI10.pdf
	FELASALI10T	Application/ Enrollment Form	Telephone Application to Standard Life and Accident Insurance Company	Initial			FELASALI10T.pdf

Standard Life

Application to Standard Life and Accident Insurance Company
[Mailing Address: P.O. Box 696850, San Antonio, TX 78269]

Issue Ages 26 - 80 Please Print - Use Black Ink

1. Proposed Insured _____ Social Security Number _____
(First Name) (Middle Initial) (Last Name)

Birthdate (Mo-Day-Yr) _____ Age _____ Sex _____ Birthstate/Birthplace _____

Height _____ Weight _____ Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced

Occupation _____ Has the Proposed Insured used tobacco or nicotine in the past 12 months?.....❑ Yes ❑ No

Residence Address: _____
(Number and Street)

City, State and Zip _____ Home Phone _____

Special Request:

2. Owner _____ Social Security Number _____ Date of Birth _____
(if other than Proposed Insured)

Address _____ Relationship _____

3. First Beneficiary _____ Social Security Number _____ Date of Birth _____

Address _____ Relationship _____

Second Beneficiary _____ Social Security Number _____ Date of Birth _____

Address _____ Relationship _____

4. a. Do you have any existing insurance or annuities in force? If none in force, indicate "none" _____

b. Will the life insurance applied for replace or use cash values of any existing life insurance or annuity policy issued by any company?..... ❑ Yes ❑ No

If Yes, Indicate which ones _____

5. Have you ever flown or do you contemplate flying as a pilot or student pilot, or engage in, or intend to engage in any hazardous avocation or sport? If Yes, complete and submit the appropriate questionnaire. ..... ❑ Yes ❑ No

PART 1 (Proposed Insured is not eligible for life insurance if any question in PART 1 is answered "Yes". If all questions are answered "No", proceed to PART 2.)

6. Are you currently hospitalized, in a nursing home, under hospice care, currently confined to a wheelchair due to disease or illness, or need personal or mechanical assistance in bathing and/or dressing?..... ❑ Yes ❑ No
7. In the past 2 years, have you had a heart attack, stroke, emphysema, cirrhosis of the liver or cancer (other than non-melanoma skin cancer)?..... ❑ Yes ❑ No
8. Have you ever been diagnosed by a member of the medical profession with acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or tested positive for human immunodeficiency virus (HIV)? ..... ❑ Yes ❑ No
9. Have you ever received an organ transplant or are you on a waiting list for an organ transplant?..... ❑ Yes ❑ No
10. Have you ever received kidney dialysis, heart valve replacement, or an implanted defibrillator? ..... ❑ Yes ❑ No
11. Have you ever been diagnosed by a member of the medical profession with any of the following conditions: congestive heart failure, Alzheimers, dementia, aneurysm, chronic hepatitis B or C, cardiomyopathy, or renal failure?..... ❑ Yes ❑ No
12. Have you ever been diagnosed by a member of the medical profession with COPD?..... ❑ Yes ❑ No
13. In the past 10 years, have you been diagnosed by a member of the medical profession with or received treatment for leukemia or lymphoma (Hodgkins or non-Hodgkins)? ..... ❑ Yes ❑ No
14. In the past 5 years, have you received treatment for alcohol or drug use, been diagnosed by a member of the medical profession with internal cancer or malignant melanoma, had a stroke, cerebral vascular accident (CVA) or transient ischemic attack (TIA), or been diagnosed or treated by a member of the medical profession for pancreatitis? ..... ❑ Yes ❑ No
15. In the past 2 years, have you been diagnosed by a member of the medical profession with coronary artery disease or atrial fibrillation or had coronary bypass surgery, coronary angioplasty, coronary stenting, or had a pacemaker implanted?..... ❑ Yes ❑ No

PART 2 (Proposed Insured may require substandard rates if any of the following is answered "Yes". If all questions are answered "No", Proposed Insured may qualify for standard rates).

16. Have you ever been diagnosed by a member of the medical profession with major depression, bipolar disorder, diabetes (requiring insulin), rheumatoid arthritis, multiple sclerosis, or Parkinson's disease? ❑ Yes ❑ No
17. In the past 2 to 10 years, have you been diagnosed by a member of the medical profession with a heart attack, coronary artery disease, atrial fibrillation or had coronary bypass surgery, coronary angioplasty or coronary stenting? ❑ Yes ❑ No
18. In the past 5 years, have you been diagnosed by a member of the medical profession with or received treatment for Crohn's disease or ulcerative colitis? ❑ Yes ❑ No
19. In the past 5 to 10 years, have you been diagnosed by a member of the medical profession with one of the following conditions: internal cancer, malignant melanoma,transient ischemic attack (TIA)? ❑ Yes ❑ No
20. Have you ever had a stroke or cerebral vascular accident (CVA)? ❑ Yes ❑ No

21. Plan _____ Plan Type: ❑ Standard Rates ❑ Substandard Rates

Initial Premium Payment _____ Face Amount _____ Payment Method _____ Payment Mode _____

FRAUD WARNING — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICATION DECLARATIONS AND AGREEMENTS — The Proposed Insured declares for himself/herself, that all of the answers in this application and any supplements to it are complete and true to the best of his/her knowledge and belief. The Proposed Insured also agrees that:

1. these answers as written: a) were given to induce the Company to issue a Policy; and b) shall form the basis for and become part of any Policy issued on the application;
2. except as otherwise provided in the conditional receipt, no Policy will be effective until it is: a) issued; b) delivered to the Applicant; c) the full first premium paid; and d) all during the lifetime and good health of the Proposed Insured;
3. the Company may issue a Policy different from that specified in this application by listing the difference(s) on the Policy Data Page, and acceptance of such different Policy will be a ratification of the changes except that no changes in: a) specified amount; and b) classification will be effective unless agreed to by the Proposed Insured in writing;
4. the Company is not bound by any statements made by anyone or any other facts known to anyone concerning the Proposed Insured if not in writing in this application or any supplement to it; and
5. only the President, a Vice President, or Secretary of the Company has the authority to waive any of the Company rights or requirements or to waive or alter any of the provisions of this application or the Policy issued on this application.

Dated at City, State	Date	Print Agent's Name
Proposed Insured's Signature	Owner's Signature	Witnessed by: Agent's Signature

USA PATRIOT ACT NOTICE — To Be Read By Or To Customer

The USA PATRIOT Act requires that we establish an Anti-Money Laundering ("AML") Program, notify customers that we must verify the identity of the owner(s) of our contracts, and collect documents and information sufficient to provide such verification. You should know that failure to provide the requested identification will result in delays in the issuance of the requested coverage and may result in a decision not to accept your application.

Identification Verified: one for each Owner/Trustee/Partner (Use additional forms if necessary.)

Owner/Trustee/Partner: Check one form of Identification:
❑ Driver's license ❑ Resident Alien Identification (green card)
❑ Passport ❑ Other: (describe) _____

Joint Owner/Trustee/Partner: Check one form of Identification:
❑ Driver's license ❑ Resident Alien Identification (green card)
❑ Passport ❑ Other: (describe) _____

The following information should be recorded exactly as it appears on the identification reviewed:

Name	Date of Birth
Street Address (not PO Box)	City, State, Zip
Number on Identification / State or Country	Identification Expiration Date

CONDITIONAL RECEIPT

Standard Life and Accident Insurance Company
[Administrative Office: P.O. Box 1850, Galveston, Texas 77553-1850]

**THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.
PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY.
DO NOT MAKE THE CHECK PAYABLE TO THE AGENT
OR LEAVE THE PAYEE BLANK.**

I have received $ _____ concerning an application for life insurance. If each of the following four conditions is satisfied fully, then, subject to the Maximum Specified Amount Limitation described below, insurance as provided by the terms and conditions of the Policy will become effective on the effective date, as defined below. **1.** The payment received with the application must equal the minimum required for the Plan. **2.** All medical examinations and tests required under the Company's application requirements must be completed and the reports of those medical examinations and tests must be received at the Company's Administrative Office within 45 days after the date of this receipt. **3.** On the effective date, as defined below, the Proposed Insured must be insurable at standard premium rates for insurance requested in the application. **4.** There is no material misrepresentation in the application.

MAXIMUM SPECIFIED AMOUNT LIMITATION: At no time and in no event shall the total liability of the Company under this receipt exceed $100,000. "Effective date" means the latest of the date the application is completed, the date all medical exams and tests are completed as required by the Company, and if the Proposed Insured requests a policy date which is later than the date of this receipt, the policy date requested by the Proposed Insured. **Refund of Payment:** If one or more of the above conditions have not been satisfied fully within 45 days after the date of this receipt, the Company's liability is limited to a refund of the premium paid. Only the President, a Vice President or Secretary of the Company has the authority to waive any of the Company's rights or requirements or to waive or alter any of the provisions of this receipt or amend it in any way.

Dated at _____ on _____ , _____
City, State Month, Day Year

_____
Signature of Licensed Agent

_____
Signature of Proposed Insured

_____
Signature of Premium Payor

SIGNATURE REQUIRED IF CONDITIONAL RECEIPT TO BE DETACHED

I hereby certify that I have read and received the conditional receipt, and agree to its terms. I understand that the Company will not permit acceptance of my payment or detachment of the conditional receipt unless this statement is true.

_____
Signature of Proposed Insured

_____
Signature of Premium Payor

Standard Life
A Member of the American National Family of Companies

Standard Life and Accident Insurance Company
Administrative Office:
[P.O. Box 1850, Galveston, Texas 77553-1850]
[888.519.5819]

Standard Life and Accident Insurance Company
[Administrative Office: P.O. Box 1850, Galveston, Texas 77553-1850]

In connection with your application, Standard Life and Accident Insurance Company (Standard Life), or its reinsurers, may obtain medical and other information for evaluation purposes. Standard Life may obtain that information from the Medical Information Bureau, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. Standard Life may also obtain an investigative consumer report on you.

[Medical Information Bureau (MIB) Pre-notification – Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Standard Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.]

Fair Credit Reporting Act Pre-notification – Federal and state laws require notification that, with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or for the appropriate fee, receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics, and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors, or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community.

AUTHORIZATION TO MY BANK

PREAUTHORIZED CHECK AUTHORIZATION

Attach Voided Check or Deposit Ticket Here and Sign Authorization

❑ Checking **❑ Savings**

Bank Information

Name _____

City _____ State _____ Zip _____

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____
Date Signed

✓ _____
Signature (as it appears on bank records)

Account Number _____

Routing Number _____

AGENT'S STATEMENT

I certify that I saw the Proposed Insured. I asked the Proposed Insured the questions in the application, and recorded the answers. The answers recorded did not conflict with my observations and knowledge of the Proposed Insured. I witnessed the required signatures. I certify that I have verified the Proposed Insured's personal information by viewing a state issued driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident (Green Card), passport or other government issued pictured I.D. card.

_____
Date

_____
Agent's Signature

_____
Agent's Code

AGENT'S SUPPLEMENT

1. What is the purpose of this insurance? ❑ Personal ❑ Business
2. If beneficiary is not a relative, explain insurable interest:

_____

3. How long have you personally known the Proposed Insured?

_____

4. By whom will the premiums be paid? ❑ Owner ❑ Applicant ❑ Other

   If Other, explain: _____

5. As an agent, do you have knowledge or reason to believe that replacement of existing business may be involved? ❑ Yes ❑ No
6. Was the application voluntary or solicited? _____

AGENT'S REPORT

During the interview, did you observe if the Proposed Insured had any physical or mental impairment with regard to walking, speaking, or clearly understanding the questions on the application? ❑ Yes ❑ No

The best time(s) to call for a telephone interview:

_____

BE SURE TO INFORM YOUR CLIENT A TELEPHONE INTERVIEW WILL BE CONDUCTED. If the Proposed Insured has a hearing problem, describe.

_____

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:

1. such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
3. a picture copy or photocopy of this authorization shall be as valid as the original; and
4. I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life New Business Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, [P.O. Box 1850, Galveston, Texas 77553.] *may inspect or copy any information used or disclosed under in authorization, if signed.*

_____
Date

_____
Signature of Applicant

_____
Witness

_____
Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other _____.

Standard Life
A Member of the American National Family of Companies

Application to Standard Life and Accident Insurance Company
[Administrative Office: P.O. Box 696850, San Antonio, TX 78269]
[888.519.5819]
Issue Ages 26 - 80

This telephone conversation will be recorded and the information you provide is your application for life insurance.

1. Proposed Insured _____
First Name Middle Initial Last Name

Birthdate (Mo-Day-Yr) _____ Age _____ Sex _____ Social Security Number _____

Height _____ Weight _____ Birthstate/Birthplace _____

Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced

Has the Proposed Insured used tobacco or nicotine in the past 12 months? ..... ❑ Yes ❑ No

Residence Address _____ City _____ State _____ Zip _____

Phone Number (_____) _____ Occupation _____

2. Owner _____ Social Security Number _____ Date of Birth _____
(if other than Proposed Insured)

Address _____ Relationship _____

3. First Beneficiary _____ Social Security Number _____ Date of Birth _____

Address _____ Relationship _____

Second Beneficiary _____ Social Security Number _____ Date of Birth _____

Address _____ Relationship _____

4. a. Do you have any existing insurance or annuities in force? If none in force, indicate "none" _____

b. Will the life insurance applied for replace or use cash values of any existing life insurance or annuity policy issued by any company? ..... ❑ Yes ❑ No

If Yes, indicate which ones _____

5. Have you ever flown or do you contemplate flying as a pilot or student pilot, or engage in, or intend to engage in any hazardous avocation or sport? If Yes, complete and submit the appropriate questionnaire..... ❑ Yes ❑ No

Special Request

PART 1 (Proposed Insured is not eligible for life insurance if any question in PART 1 is answered "Yes". If all questions are answered "No", proceed to PART 2.)

6. Are you currently hospitalized, in a nursing home, under hospice care, currently confined to a wheelchair due to disease or illness, or need personal or mechanical assistance in bathing and/or dressing? ..... ❑ Yes ❑ No
7. In the past 2 years, have you had a heart attack, stroke, emphysema, cirrhosis of the liver or cancer (other than non-melanoma skin cancer)?..... ❑ Yes ❑ No
8. Have you ever been diagnosed by a member of the medical profession with acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or tested positive for human immunodeficiency virus (HIV)? ..... ❑ Yes ❑ No
9. Have you ever received an organ transplant or are you on a waiting list for an organ transplant? ..... ❑ Yes ❑ No
10. Have you ever received kidney dialysis, heart valve replacement, or an implanted defibrillator? ..... ❑ Yes ❑ No
11. Have you ever been diagnosed by a member of the medical profession with any of the following conditions: congestive heart failure, Alzheimers, dementia, aneurysm, chronic hepatitis B or C, cardiomyopathy, or renal failure? .. ❑ Yes ❑ No
12. Have you ever been diagnosed by a member of the medical profession with COPD?..... ❑ Yes ❑ No
13. In the past 10 years, have you been diagnosed by a member of the medical profession with or received treatment for leukemia or lymphoma (Hodgkins or non-Hodgkins)? ..... ❑ Yes ❑ No

14. In the past 5 years, have you received treatment for alcohol or drug use, been diagnosed by a member of the medical profession with internal cancer or malignant melanoma, had a stroke, cerebral vascular accident (CVA) or transient ischemic attack (TIA), or been diagnosed or treated by a member of the medical profession for pancreatitis? ..... ❑ Yes ❑ No
15. In the past 2 years, have you been diagnosed by a member of the medical profession with coronary artery disease or atrial fibrillation or had coronary bypass surgery, coronary angioplasty, coronary stenting, or had a pacemaker implanted? ..... ❑ Yes ❑ No

PART 2 Proposed Insured may require substandard rates if any of the following is answered "Yes". If all questions are answered "No", Proposed Insured may qualify for standard rates).

16. Have you ever been diagnosed by a member of the medical profession with major depression, bipolar disorder, diabetes (requiring insulin), rheumatoid arthritis, multiple sclerosis, or Parkinson's disease? ..... ❑ Yes ❑ No
17. In the past 2 to 10 years, have you been diagnosed by a member of the medical profession with a heart attack, coronary artery disease, atrial fibrillation or had coronary bypass surgery, coronary angioplasty or coronary stenting? .. ❑ Yes ❑ No
18. In the past 5 years, have you been diagnosed by a member of the medical profession with or received treatment for Crohn's disease or ulcerative colitis? ..... ❑ Yes ❑ No
19. In the past 5 to 10 years, have you been diagnosed by a member of the medical profession with one of the following conditions: internal cancer, malignant melanoma, transient ischemic attack (TIA)? ..... ❑ Yes ❑ No
20. Have you ever had a stroke or cerebral vascular accident (CVA)? ..... ❑ Yes ❑ No

PLAN INFORMATION

21. Plan_____ Plan Type: ❑ Standard Rates ❑ Substandard Rates

Initial Premium Payment _____ Face Amount _____

Payment Method _____ Payment Mode _____

FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICATION DECLARATIONS AND AGREEMENTS

In order to complete your application I need to read you some declarations and agreements which will be made part of your application for life insurance:

The Proposed Insured declares for himself/herself, that all of the answers in this application and any supplements to it are complete and true to the best of his/her knowledge and belief. The Proposed Insured also agrees that:

1. these answers as written: a) were given to induce the Company to issue a Policy; and b) shall form the basis for and become part of any Policy issued on the application;
2. except as otherwise provided in the conditional receipt, no Policy will be effective until it is: a) issued; b) delivered to the Applicant; c) the full first premium paid; and d) all during the lifetime and good health of the Proposed Insured;
3. the Company may issue a Policy different from that specified in this application by listing the difference(s) on the Policy Data Page, and acceptance of such different Policy will be a ratification of the changes except that no changes in: a) specified amount; and b) classification will be effective unless agreed to by the Proposed Insured in writing;
4. the Company is not bound by any statements made by anyone or any other facts known to anyone concerning the Proposed Insured if not in writing in this application or any supplement to it; and
5. only the President, a Vice President, or Secretary of the Company has the authority to waive any of the Company rights or requirements or to waive or alter any of the provisions of this application or the Policy issued on this application.

Normally, we would get your handwritten signature, but, since we are taking your life insurance application over the phone, we have to obtain your consent by voice recording which constitutes an electronic signature under the law. If the information you have provided on the application is true and correct, if you agree to the statements just read to you and if you consent to the use of this recording as our electronically signed application, please state your name, birthdate and "I agree".

_____ _____

Dated at City, State Date

_____ _____

Proposed Insured's Signature Owner's Signature

AGENT'S STATEMENT

1. What is the purpose of this insurance? ❑ Personal ❑ Business
2. If beneficiary is not a relative, explain insurable interest: _____
3. How long have you personally known the Proposed Insured? _____
4. By whom will the premiums be paid? ❑ Owner ❑ Applicant ❑ Other If Other, explain: _____
5. As an agent, do you have knowledge or reason to believe that replacement of existing business may be involved?..... ❑ Yes ❑ No
6. Was the application voluntary or solicited? _____

The agent is usually asked to sign the application as a witness. Since this application is being taken over the phone, we have to obtain the agent's signature by voice recording which constitutes an electronic signature under the law. Please state that you have participated in the telephone application and wish this recording to be your electronic signature by stating your name, birthdate and "I agree".

_____
Date

_____ _____ _____
Print Agent's Name Agent's Signature Agent's Code

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:

1. such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
3. a picture copy or photocopy of this authorization shall be as valid as the original; and
4. I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life New Business Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY,[P.O. Box 1850, Galveston, Texas 77553] *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Since we are taking your life insurance application over the phone and cannot obtain a physical handwritten signature on this authorization we have to obtain your consent by voice recording which constitutes an electronic signature under the law. If you agree to the authorization just read to you and if you consent to the use of this recording as your electronic signature, please state your name, birthdate and "I agree".

Date

Applicant's Signature

DISCLOSURE NOTICE

Standard Life and Accident Insurance Company

[**Administrative Office: P.O. Box 1820, Galveston, Texas 77553-1820**]

In connection with your application, Standard Life and Accident Insurance Company (Standard Life), or its reinsurers, may obtain medical and other information for evaluation purposes. Standard Life may obtain that information from the Medical Information Bureau, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. Standard Life may also obtain an investigative consumer report on you.

[Medical Information Bureau (MIB) Pre-notification – Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Standard Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.]

Fair Credit Reporting Act Pre-notification – Federal and state laws require notification that, with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or for the appropriate fee, receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics, and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors, or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community.

AUTHORIZATION TO MY BANK

PREAUTHORIZED CHECK AUTHORIZATION

Bank Information

❑ **Checking** ❑ **Savings**

Name

City State Zip

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

If you want this voice recording to constitute your electronic signature on this authorization to your bank, please state your name, birthdate and "I agree to this authorization".

Date Signed

✓ Signature

Account Number _____ Routing Number _____

SERFF Tracking Number:	*AMNA-126820721*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46972*
Company Tracking Number:	*SLAICO - FELA10*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SLAICO - FELA10*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Readability Certification - FELASALI.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability

Comments:

Attachments:

MEMORANDUM OF VARIABLE MATERIAL - FELASALI10.pdf

MEMORANDUM OF VARIABLE MATERIAL - FELASALI10T.pdf

Standard Life and Accident Insurance Company

READABILITY CERTIFICATION

We hereby certify that the following form(s), meet the requirements of the Readability Insurance Policies Act:

Form	Form Name	Scoring(s)
FELASALI10	Application to Standard Life and Accident Insurance Company	
	as scored with the policy form	51.3
FELASALI10T	Application to Standard Life and Accident Insurance Company (Telephone)	
	as scored with the policy form	50.2

Rex D. Hemme
Senior Vice President & Actuary
Standard Life and Accident Insurance Company

tyra.reed@anico.com
Phone: (409) 763-4661 x5222 Fax: (409) 766-6933

Standard Life and Accident Insurance Company

MEMORANDUM OF VARIABLE MATERIAL FOR
FELASALI10
July 19, 2010

This memorandum was prepared for use with FELASALI10, a life application for Standard Life and Accident Insurance Company

Variable material contained within the form denoted by use of brackets.

Variable Material

The form contains the following permissible variable material:

Mailing Address
Administrative Office Address
Home Office Address
Telephone Number

The above noted items, if changed, will be changed in accordance with department standards. It is understood that the items noted above may be changed without notice or prior approval.

The form also contains the following variable fields, considered illustrative:

Medical Information Bureau (MIB) Pre-notification - the MIB pre-notice text has been denoted as variable material to allow for updates as provided by the MIB. This field will not vary on an individual basis and would only be updated should updates from the MIB, Inc. be required for new issues.

We certify to the following:

- The final form issued to the consumer will not contain brackets denoting variable text;
- Any variable text included in this Statement of Variability will be effective only for future issues;
- The use of variable text will be administered in a uniform and non-discriminatory manner, and will not result in unfair discrimination;
- Only text included in this Statement will be allowed to be used on the referenced forms received by consumers; and
- Any changes to variable or permissible ranges of values will be submitted for approval prior to implementation as required.

Standard Life and Accident Insurance Company

MEMORANDUM OF VARIABLE MATERIAL FOR
FELASALI10T
July 19, 2010

This memorandum was prepared for use with FELASALI10T, a telephone life application for Standard Life and Accident Insurance Company.

Variable material contained within the form denoted by use of brackets.

Variable Material

The form contains the following permissible variable material:

Mailing Address
Administrative Office Address
Home Office Address
Telephone Number

The above noted items, if changed, will be changed in accordance with department standards. It is understood that the items noted above may be changed without notice or prior approval.

The form also contains the following variable fields, considered illustrative:

Medical Information Bureau (MIB) Pre-notification - the MIB pre-notice text has been denoted as variable material to allow for updates as provided by the MIB. This field will not vary on an individual basis and would only be updated should updates from the MIB, Inc. be required for new issues.

We certify to the following:

- The final form issued to the consumer will not contain brackets denoting variable text;
- Any variable text included in this Statement of Variability will be effective only for future issues;
- The use of variable text will be administered in a uniform and non-discriminatory manner, and will not result in unfair discrimination;
- Only text included in this Statement will be allowed to be used on the referenced forms received by consumers; and
- Any changes to variable or permissible ranges of values will be submitted for approval prior to implementation as required.